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Peter Robinson Good morning, everyone. Good to see so many people here in person and of course, our colleagues online. Happy to see you all as well. My name is Peter Robinson. I have the privilege of calling to order the...

Peter Robinson Is it a special?

Shelly Glock No.

Peter Robinson This meeting of the Establishment and Project Review Committee. And of course, welcome welcoming everybody. Just a few notes in terms of rules of the road. Webcasting, I want to remind council members, staff and the audience that this meeting is subject to the open meeting law and is broadcast over the internet. The webcasts are accessed at the Department of Health's website NYHealthCare.Gov. The on-demand webcast will be available not later than seven days after the meeting for a minimum of thirty days, and then a copy will be retained in the department for four months. A few other suggestions for everyone. Because there is synchronized captioning. I'm going to take another sip of coffee here. It is important that people do not talk over each other. Captioning cannot be done correctly with two people speaking at the same time. For those of you that do speak, please state your name the first time and briefly identify yourself as a council member or member of the department staff. That will help the broadcasting company in their recording of the meeting. As we always remind you, the mics are hot, meaning that they pick up every sound. I therefore ask that you avoid making noises like rustling of papers next to the microphone and also be sensitive about personal conversations or sidebars as the microphones will pick up this kind of chatter. And then, as a reminder for the audience, there is a form that needs to be filled out before you enter the room, which records your attendance at meetings. It is required by the Joint Commission on Public Ethics in accordance with Executive Law Section 166. The form is posted at the Department of Health's website, same w w w I mentioned before under Certificate of Need. In the future you can fill out the form prior to the council meetings. Thank you for your cooperation as we try to do everything as prescribed by law.

Peter Robinson With that preamble, I think we have a very exciting agenda ahead of us today.

Peter Robinson Let's begin.

Peter Robinson Application 2 1 1 0 9 4 C, New York Presbyterian Hospital, New York Weill Cornell Center in New York County. Noting a conflict and recusal by Dr. Kalkut and Dr. Lim. I assume those folks will step away from their videos if they are in front of them so that we can count them as being recused.

Lito Gutierrez Mr. Robinson.

Peter Robinson Yes?

Lito Gutierrez This is Lito Gutierrez here.

Lito Gutierrez May I ask that people that identify themselves about an abbreviation and a telephone number be identified before we proceed?

Peter Robinson Yes, absolutely.

Sabina Lim I think I was just abstaining and not recusing. Could I confirm with Colleen about that?

Shelly Glock If she wants to abstain, that's fine.

Peter Robinson If you choose an abstention, you can remain.

Sabina Lim Okay.

Peter Robinson Thank you.

Peter Robinson Just a second, Dr. Gutierrez. We're confirming.

Peter Robinson We do know that the 8 9 1 number is a state person. Department person, not state department. State Department of Health.

Peter Robinson Yep.

Peter Robinson We're okay.

Peter Robinson Thank you.

Peter Robinson Back to the application.

Peter Robinson This is to certify an adult heart transplant service and acquire requisite equipment. The department is recommending approval with conditions and a contingency.

Peter Robinson May I have a motion?

Peter Robinson Dr. Gutierrez.

Peter Robinson A second by Dr. Torres.

Peter Robinson Shelly.

Shelly Glock Good morning. This is Shelly Glock with the department. This project will be presented by Nancey who's with the department's Division of Hospital Services.

Peter Robinson Not yet.

Nancey Agard My name is Nancey Haggard. I work in the division of hospitals and diagnostic and treatment centers. I'm the Director of the Organ Donation and Transplant

Program within that division. As you just noted, the department recommends approval of this new heart transplant application filed by New York-Presbyterian Cornell Medical Center with contingencies and conditions. Approval of this application would bring the number of heart transplant programs in New York State up to eight. Most of them. And actually moving New York toward a number more consistent with the number of heart transplant centers in other large states. Four of the existing programs are already in the New York City area. That includes Columbia, NYU, Mount Sinai and Montefiore. There are two other programs in the region one being at North Shore and the other one being at Westchester and one upstate program located in Rochester at the University of Rochester Strong Memorial Medical Center. As far as this application goes, the department did undergo an extensive review as well as we pulled together a review committee, which is our practice. The review committee consists of representation from the transplant council as well as experts from non-conflicted out of state programs and regions and included in a heart transplant cardiologist, heart transplant surgeon, a representative from a reputable organ procurement organization and a transplant program administrator, which is what our historically our process has been to evaluate applications for CON's. The review committee was provided with a variety of information, including parts of the application and relevant data from the OPTN, UNOS and SRTR, which are a lot of gobbledygook acronyms, but really means the agencies involved in oversight of transplantation programs. The review committee is recommending, and the department is recommending approval based on primarily five factors. The first one is disease burden and risk factors. Now, the applicant is focusing this program on the communities of Brooklyn and Queens. And when we looked at the data about Brooklyn and Queens, as well as New York State in general, what we noted was the number one cause of death in New York is heart disease with a significant disparity related to race and ethnicity. The rates of diabetes and hypertension are higher in these communities than they are in the rest of New York City. Those are known risk factors for contributing to the need for heart transplantation as a result of heart disease. The target communities are actually rather diverse as well. Approximately 52% of the residents of Brooklyn identify themselves as African American or Hispanic, with an almost 12% Asian population. The residents of Queens identify 49% of them identify themselves as African American and 29% as Asian. So, that reflects a rather diverse community. 10% of the population of Queens is living at or below the poverty level, whereas 20% of the population of Brooklyn are living at or below the poverty level. Not unlike the rest of New York State and New York City, the population of those two burrows are aging. Also, like me, who is aging every day, I feel like. Perhaps the rest of you feel that way as well. The information the applicant has provided is that their projections for the hospitals within their network, within that community, is that the percentage of heart failure discharges from the Brooklyn Hospital will increase 11% in the next ten years, whereas from their Queens Hospital they project a 17% increase in heart failure discharges. Thus, really indicating that there is a need and a disease burden within the target communities. The second factor that the department and the review committee used in helping to make this decision was the existence of a network of care within the Brooklyn and Queens community. About five years ago or so, New York Presbyterian Hospital Network added New York Presbyterian, Brooklyn and then Queens Hospital to their network. Since that period of time, they've become more cognizant and recognize the need to enhance not only primary care in the communities, but also specialty care, including cardiology, heart failure and advanced heart failure care. They have also used this time to enhance the number of physicians and providers in the communities and to standardize their treatment plans and protocols for treatment of heart failure and advanced heart failure. They've trained the physicians in their network. They have them rotating through their Columbia and Cornell campus to maintain their competence and their knowledge of these protocols. In addition, certainly a number of patients from the Brooklyn

Hospital and from the Queens community have needed advanced heart failure care. They have sent them to Cornell to get their VAD if they needed a ventricular assist device. If they needed a heart transplant evaluation, they primarily sent them to Columbia, but were able to provide both their pre and post care in the community. They've again sort of enhanced that network closer to where the residents live. The third factor that we took into consideration was the results of a survey that the Department did of the existing heart transplant programs. The majority of the providers in the New York City area identified that they were already working at capacity. Now, this was a question that we asked Presbyterian when they came forward with this application and said, you already have an existing program at Columbia. Is it necessary to add another program? What is your thinking about adding another program at Weill Cornell? Their response was that they were really already at capacity in the Columbia site. They would need much more room, more beds, etc., and that they needed to add capacity. Thus, the proposal to open a new program at Cornell. The only hospital in the city that identified that they had capacity was Mount Sinai and they identified that they would be able to do more transplants if they had more hearts available to them. This is sort of a supply and demand issue to some extent. The fourth factor that we took into consideration when we were considering what kind of a recommendation to make about this application was the strength of the proposal provided by the Weill Cornell New York Presbyterian Network. The fact that Cornell already has three existing transplant programs, they're familiar with how to run a transplant program, which has an extensive infrastructure that's required and really is heavily overseen by both. The fact that they are aligned with Colombia, which has a very good history as a very active, very high-volume heart transplant program with good outcomes. They're working to combine and standardize their treatment protocols. They did not have to start from scratch like most other programs do when they're starting up. There is support within the network and within their sister facility. The fact that the program was focused on communities that are diverse, that do have needs, and it was seen as a strength for this application. I'm sorry. I'm just looking down at my notes to make sure I don't miss anything here. The last thing really was that it was a strong program. It was a strong application. They had a strong quality assurance performance improvement plan in place. Their personnel are very experienced and have time in the field. Their support structure is already established and strong. We felt that this was a strong application. And that was really reinforced by the fact that last December, which is the last factor that was taken into consideration, was that the program did receive approval. Based on those sorts of five factors, the review committee and the department in closing, are recommending approval of this program with contingencies and conditions.

Peter Robinson Thank you.

Peter Robinson Okay, I'll turn to the committee first. Are there any questions of the department or the applicant?

Peter Robinson Yes, Ann.

Peter Robinson You're on mute, Ann.

Peter Robinson There you go.

Ann Monroe I do have a question for the department. Did I understand you to say that the current heart transplant unit can't do any more, because there aren't any more hearts available? Could they expand their services or their program if more hearts were available? If it's a lack of hearts, how is that going to make a difference?

Nancey Agard There were sort of two things mixed together there. Columbia, the New York Presbyterian Hospital Network and Columbia has said they do not have more capacity. It's not just limited by heart. It's more based on space and OR's and that type of a thing. Their point and someone from the network could certainly respond to that better than I could. Their point was that they really did not have capacity to continue to do more volume at that space. Your reference to more hearts is really and actually that is a question that the review committee bounced around among themselves. Would opening a new program bring in more hearts? Their conclusion based on the history, which is since, you know, we opened up two new heart programs in 2018, one at NYU and one at North Shore. NYU came out of the gate with the horses running. Whey the opening of new programs, more hearts came into the state and more transplants were done. It was the feeling of the review committee that because of the history that we have going here in New York State, as well as the fact that the allocation rules have changed and brings in more hearts to New York and if the program adds people to their list that are sick, they will be higher status on the list. That will all result in more hearts coming into New York available for transplant. It's kind of a multifactorial thing that we have one factor working sometimes together, sometimes against each other.

Ann Monroe I appreciate that they're going to locate the target, these high risk, vulnerable, marginalized communities. We've seen over and over that say you're going to do that and being able to actually build the relationships of the community that will make that happen differ. What evidence did the applicant present that they in fact have or have a plan to build the relationships with the community that will result in a more effective heart cardiac care. I just worry that just by saying it or locating community does not mean they're going to reach that population. What have they said about that?

Nancey Agard Again, this is probably a good question for the applicant.

Peter Robinson Let's bring it to the applicant.

Peter Robinson I'm going to ask the applicant to come forward.

Jeffrey Kraut As they're coming up, just to clarify something you said. We've had a process in the state. By and large, we have about seven or eight major health systems, probably accounting for 80% of the care that's delivered in the New York Metropolitan area, at least at the Downstate level. Based on what you said is the committee, we are establishing with this application a new president of need. You just basically said the issue is it's always been looked at as organ limited. What we're saying, as we've approved more programs, we've increased the availability of organs, which was something counter to the general wisdom up until that point. So, that's a new piece of data for us to understand in the context of the application before us. I think that that's an important issue, because what this will do if we approve this application, you will see instead of each system having kind of one center, we would be then considering applications for multiple transplant programs in multiple locations within a health system. We're kind of establishing a new precedent here with respect to the issue of need.

Nancey Agard This is the first time this has happened.

Jeffrey Kraut Yes.

Nancey Agard Two programs within a system.

Jeffrey Kraut So, that's an issue. And then, you know, for the applicant, you know, the issue is why do you need to, but you've kind of explained that. We'll have some other questions, but I know you have questions.

Hugh Thomas Hugh Thomas, member of the counsel. It really, I think Mr. Kraut just hit my question, which is one of need. I'm trying to understand the definition in this context a little bit. Network need has been demonstrated at least that's what I heard. New York Presbyterian Network made it clear they don't have the capacity at Columbia. They're going to expand into Cornell. A long history of doing this. You also said that Mt. Sinai had capacity. Now, I presumed inside of that statement that Northwell and NYU do now. And so, in that context, did the committee discuss regional need versus network need? I understand the distinction. I understand reputationally everybody's reputation here. A fairly significant departure in this kind of a quite narrow service, at least in my experience. I guess my narrow question is only one of the programs has capacity. They have expressed that they can't provide care, because they can't get hearts which probably a function of the size of their network or whatever and the formulas inside of allocation. Maybe you can expand on it, or the applicant can expand on that. Again, it's not a question of the need at Columbia. They don't have the space. Cornell is their partner or affiliate. I get that. This is just to amplify what Mr. Kraut just said. This is a change.

Nancey Agard I have to tell you, I talked to my committee members a lot. Actually, and we should probably back up to what is need. Right now, actually, the Transport Council has a subcommittee looking at the need regulations for transplant. We have been looking at that for about 18 months. We are. Knock on wood. Going to start writing our paper and suggesting regulations within a fairly short period of time. I actually tried to utilize the model that we were moving toward developing, which is about need in the identified target communities. When we look at the target communities, from what we could tell, it does look like there is need. The fact that there wasn't, you know, history from history. When we opened new programs, there was no negative impact on the existing programs. We actually not only did the new program start to perform more transplants, the existing program started to perform more transplants. Now, what was very nicely going on at the same time was the changes in what was going on and changes to the allocation rules. Prior to that, New York had been extremely disadvantaged in getting, you know, organs of all types, actually, primarily livers. That was where the huge problem lie. That has really the change in the allocation rules which are also going to continue to evolve as they move toward continuous allocation versus the circle model, they're using with most of the services right now. The other factor that's actually going to feed into this and make this more of a wild, wild west for a little while is the fact that the whole conditions for coverage of the organ procurement organizations are changing and that there's a change in the definition of transplant. A change in the definition of donation. If the opioids don't get better, we have one high performing one and the other two are in the sort of okay zone, but maybe not and one is below. If I'm remembering that correctly, I may not be right. Everybody's going to have to learn to work together better, improve their donor identification of potential donors, donor management to improve and increase the number of organs available. There's going to be all kinds of things going on in the next four to five years that are going to impact what this whole scenario looks like.

Peter Robinson Thank you.

Peter Robinson Let me just ask the applicants to introduce themselves.

Karen Good morning. I'm Karen. I'm the SVP and the Chief of Regulatory Planning for New York Presbyterian.

Deepa Good morning. I'm Deepa. I am the Senior Vice President and Chief Medical Officer at New York Presbyterian and on faculty at Columbia as a cardiologist.

Neal Good morning. Neal. I'm the Director of Heart Failure, Heart Transplant and Mechanical Circulatory Support across the Enterprise in New York-Presbyterian, Columbia and Cornell.

David Good morning, everyone. I'm David. I'm the Medical Director of the Heart Transplant program at Weill Cornell.

Mike Morning. I'm Mike. I'm the Chief Financial Officer.

Frank Cicero Frank Cicero.

Peter Robinson Thank you.

Peter Robinson I just want to go back to Ann Monroe's question. I think you guys unless you need her to tee that up again. Just understanding that the system capacity question I think is the one that she was focused on.

Applicant Just to make sure I'm answering the right question, because there are a few things there from our perspective at New York Presbyterian transplant care and the care of patients is usually a relatively long length of stay. The patients come in our intensive care units, and they can stay for 20 to 30 days post. The ability for our integrated program, which is really an extension to the campus to utilize ICU beds and ORs at the Weill Cornell campus with our integrated care team is really what the capacity question is within our own system. I'll pause and see if I answered your question if you want to redirect.

Ann Monroe Thank you.

Ann Monroe I think my question was a little more focused and that was locating in higher risk communities and saying you're going to prioritize them are one thing. Actually, having the relationships in the community that make it more likely that these populations will come forward is another. I was asking moving forward, why do you think that locating it there will be enough to just bring people in and what are you doing to build relationships? I think that was more my question.

Applicant Ann, I think that's a great question. New York Presbyterian as a system, as mentioned earlier by Nancey has in our system, New York Presbyterian, Brooklyn Methodist Hospital in New York Presbyterian, Queens. As we brought those systems on board, they have affiliated medical groups and independent physicians that partner. One of the things we feel strongly about, about our care model is that we are investing in bringing primary care physicians, cardiologists and advanced heart failure specialists, which I'll turn over to practice in Brooklyn and Queens to be part of a shared care model. The patients who we care for in Brooklyn feel connected to their clinicians. We feel very strongly for those, frankly, a relatively small subset of patients that may ultimately need heart transplantation at the care of their provider being the same provider who provides their cardiology care, treats their heart failure in the community being part of that care team, if they do need heart transplantation or VAD is one key piece of that. In addition, New York

Presbyterian has had a long history of partnering with the communities. I want to speak briefly about our Heart Smarts program, which started in 2012. We've been training health care ambassadors, nearly 200 of them, about 70% that are in Brooklyn and Queens that work in faith-based organizations to provide education, about nutrition, about diabetes, about high blood pressure. We continue to work with community-based organizations to strengthen that connection. New York Presbyterian as a system, as a health care provider, is seen as a partner to our local communities. I do want to pass that on to share why we feel so strongly about the clinical model and its ability to really make those connections with patients.

Applicant You are actually touching a very crucial point in the management of heart failure. In the second that you tell someone you have the heart failure is a patient for life. This is not breaking a hand and you going to fix it. This is going to be a disease that's going last for him until he will die. So, the trust is the number one key. In order to develop this trust, what we decide to develop is a system that will have heart valve specialties that are very, very rare. As you know, there is not a lot in the country. To be able to recruit them to a model that integrates them. All the provider that we recruited to Brooklyn and Queens share a faculty appointment in Cornell to spend 25% of the time in the Cornell campus in order to maintain their skill as an advanced provider. Side by side, because that's a seat in the community with the patient. Another element that is a crucial element with their colleague. The majority of cancer patients in the country, not only in the state. He's not taking care by heart specialist. Not taking care of by general cardiology or internal physician. Suddenly when you have a heart valve specialist next to you, you're going to send this patient to him, and he may get the care of this patient. Deserves the trust, the access, the equity. We were able to recruit elite heart for the provider into our community, people that we train in our system at Columbia and Cornell or sometimes outside of our system in excellent institutions elsewhere. We have been able to become part of the community. Is one part of it. A lot of activity in the community, a lot of outreach with the physician and a lot of education. We created a system that is open to all the providers that want to join once a month to a CME about heart if you are a provider in cardiology or internal medicine and to educate them about our capability and what we are doing. Due to the Zoom, it became very popular. Sometimes we have 150 people join in the Zoom. Actually, it's an average 150. We reach almost 320 provider logging in. It's happening every month already for a two and a half year.

Ann Monroe I think I have a much better understanding of your connections to the community.

Ann Monroe Thank you for that.

Applicant No, but it's a crucial point.

Applicant Thank you for the question.

Peter Robinson Thank you.

Peter Robinson Other questions from the committee?

Jeffrey Kraut You talked before about an integrated program across the system. Do you have standardized policies and procedures between the two of them? Is there unified clinical management?

Applicant Yes, we do have standardized policies, procedures and clinical protocols for both inpatient care, outpatient care and the transitions of care which are so crucial in these patients at all of our facilities that are also integrated into our now single.

Jeffrey Kraut Who is in charge of the transplantation program over both programs?

Jeffrey Kraut You are.

Applicant Mr. Kraut, I will even emphasize more than that. We have unified protocol. The protocol, actually, we have a protocol committee that meets routinely and all the provider in all campuses in Brooklyn, in Queens, in Columbia, in Cornell, in Lawrence hospitals. That's where we are. Programs are joining. We are setting. This is the program. We actually unified unify the protocols to heart failure to mechanical circulatory support LVAD and to transplantation. Far more than that, we have an overarching program, a very innovative program called Centralized Heart Failure. It's overseeing all those patients. A patient with heart failure, if a provider thinks he's challenging, can assign him to this program. And by signing into the program, they have a very clear protocol. It doesn't matter from where the patient is coming if the patient is from Brooklyn, Queens, Columbia or Cornell, you get exactly the same protocol.

Peter Robinson Thank you.

Peter Robinson We have a question for Mr. Lawrence. I almost called you doctor again.

Mr. Lawrence Okay. One day, maybe I'll take that promotion.

Mr. Lawrence Good morning. Harvey Lawrence, member of the council. You know, I guess I'm following up on the question that Ms. Monroe asked, and that is, it was really pleasing to hear about your involvement in the community and in your program, the ambassadors. I think it's wonderful initiatives. How do you manage those patients that are either under-insured or indigent in your system? What is the level of charity care that you provide throughout the system or in Brooklyn or in Queens at this point?

Applicant We'll just have our CFO address that question.

Applicant Good morning and thank you for the question.

Applicant New York Presbyterian has a very robust charity care policy. To give you some context, we had about 7,000 applications, patients who applied for or we helped apply for Medicaid. 97% of the time we were successful securing that. We had an additional 7,000 patients who applied for financial assistance. 99% of the time we were successful in providing discounted or free care for those patients. In total, in 2020, New York Presbyterian provided over 65 million of free or discounted care. We have a very robust commitment to ensuring that all folks in all of our markets that are serviced receive the care they need.

Mr. Lawrence Thank you.

Peter Robinson Thank you.

Peter Robinson Any other questions from the committee?

Peter Robinson Seeing none, I'm going to thank you guys and excuse you from the table.

Peter Robinson I don't have anybody else listed, but is there anybody else from the public that wishes to speak on this application?

Peter Robinson Hearing none, I'm going to call the question.

Peter Robinson All in favor?

All Aye.

Peter Robinson Any opposed?

Peter Robinson Any abstentions?

Peter Robinson The motion carries.

Peter Robinson We can have Dr. Kalkut return if we can reach out to him.

Peter Robinson Thank you very much.

Peter Robinson Application 2 1 2 1 7 4 C, Westchester Medical Center in Westchester County. This is to construct a five-story inpatient bed tower on the main campus to house 96 beds, 41 ICU beds and 55 medical surgical beds and with shelf space on the fifth floor with no change in total certified beds. The department is recommending approval with conditions and contingencies.

Peter Robinson A motion, please.

Peter Robinson By Dr. Gutierrez.

Peter Robinson A second by Dr. Berliner.

Peter Robinson Ms. Glock.

Shelly Glock Thank you.

Shelly Glock Westchester Medical Center is an 895 bed not for profit hospital. It requests approval for construction of a new inpatient bed tower on the medical center's main campus in Westchester County. Westchester Medical proposes to construct this five story 162,000 square foot building adjacent to the Maria Ferrari Children's Hospital, which will be connected to the original University Hospital building by a corridor. The building will be able to accommodate 128 private rooms. Initially 41 intensive care unit beds and 55 bed surge beds for a total of 96 will be moved from the current location at Westchester Medical Center to floors two to four in the new tower. The fifth floor will remain shelf space that can accommodate another 32 beds. The movement of beds to the new tower will allow Westchester Medical Center to offer nearly 100% private rooms. Goals for the project include improved patient experience, greater pandemic readiness, full compliance with current codes, improve infection control, improved efficiency, and also the capacity to meet increased demand for tertiary services. The total project cost of 165.8 million will be funded through equity in a tax-exempt bond issuance by the Westchester County Health Care Corporation. Based upon a review of regulatory compliance, public needs and

financial feasibility, the department is recommending approval with conditions and a contingency.

Peter Robinson Thank you very much.

Peter Robinson Questions from the committee?

Jeffrey Kraut The only thing I have a question about is the capital cost. They had to do the estimates as of a certain date and they're probably not complete drawings is my guess. It's just comparable to other CON's we've approved of this magnitude. I just hope they have the economic capacity. Well, they'd have to come back anyway. If it's greater than 10%, you're going to have to review it. It's not a reason to turn it down. I suspect that we will see this application again sometime in the future. It's a great price if they can get it. It's no reason to speak against the application. It's more of a curiosity.

Peter Robinson I just have a general comment here. I appreciate the fact that there's not an adjustment in total certified beds. I continue to be mindful and will probably, as other applications come forward of this almost careful notion of staying within licensed bed capacity. I think even as a council, we are probably and as a department, we need to rethink this a little bit. Maybe this is a topic that goes to the planning committee as well. You may want to actually think about having that as a topic for the planning committee. This pandemic and the stress that's placed on our resources, including the physical and bed capacity, but certainly not limited to that, has suggested that we're still pretty much operating on the margin with regard to the ability of the health system to expand and flex as these surges and epidemics hit us and require these facilities and these services. Again, this is this application is fine. I have no issue with it. It just raises the question broadly for me, and I just would think that this might be a topic that we could take a look at with the department going forward.

Peter Robinson Any other questions on this application?

Peter Robinson I note that the applicant is here for questions only.

Peter Robinson Is there anyone from the public that wishes to speak?

Peter Robinson Will call the question, all in favor?

All Aye.

Peter Robinson Thank you.

Peter Robinson Any opposed?

Peter Robinson That motion carries.

Peter Robinson Thank you very much.

Peter Robinson This next application. Dr. Kalkut, you're back out of the room again. Dr. Lim is now noted as an abstention.

Peter Robinson This is application 2 1 2 2 1 2 C, NYU Langone Orthopedic Center in New York County to certify ambulatory surgery multi-specialty to certify an ambulatory

surgery multi-specialty center and perform renovations to add an 18 OR ambulatory surgery center in the extension clinic located at 333 East 38th Street in New York. The department is recommending approval with conditions and contingencies.

Peter Robinson A motion by Dr. Gutierrez, a second by Dr. Torres.

Peter Robinson Ms. Glock.

Shelly Glock NYU Langone Hospitals is an existing New York voluntary, not for profit corporation. This project is requesting approval to construct a hospital extension clinic at 333 East 38th Street in New York County that will function as an ambulatory surgery center specializing in orthopedics, gynecology, general surgery and reconstructive plastic surgery. The AFC will be located on three currently vacant floors in an existing 12 story building owned by NYU Langone and will include 18 OR's, 81 prep parking bays, clinical offices and supporting clinical support areas as well as the central sterile processing department. NYU Langone Hospital's experience and extended lead time of several weeks for scheduling less complex surgical cases. Will allow NYU Langone to shift some of the outpatient procedures that don't require a post-operative hospital stay from the hospital to an outpatient setting. Will allow NYU Langone to freed up capacity for higher acuity surgeries at the hospital and provide flexibility for future OR renovations. The larger operating rooms will accommodate robotics, enabling NYU Hospital to better meet demand for such procedures using such equipment. The total project cost of just over 189 million will be met via accumulated funds. Based on a review of regulatory compliance, public need and financial feasibility, the Department is recommending approval with conditions and a contingency on the project.

Peter Robinson Thank you.

Peter Robinson Questions from the committee?

Ann Monroe I have one.

Peter Robinson Yes, please.

Peter Robinson Go ahead, Ms. Monroe.

Ann Monroe It's not so much of this proposal, but I am asking the staff who do the write ups. I really would like to see the breakout of payment, which you have. And at the same time, what the community demographics are.

Peter Robinson Could you say that last part again?

Peter Robinson The demographics for the community.

Jeffrey Kraut That's not as simple as you say. You have to define community different for large regional health centers. So, you know, you're thinking in terms of a single hospital that may have five zip codes around it to represent its community, which may in fact be what you want to see. You look at a program like this, the community is going to be a population base of between 5 and 6 million people. It's going to be the demographics of New York City, because like the previous applicant, they're drawing people from wide geographies. I happen to agree with you. That gives you a frame of reference of essentially patient origin. You might want to ask for what's the anticipated patient origin

and what are the demographics of the communities that you draw those patients from? Because I suspect, and this is where we get into, you know, we touch the issues of equity and access and all those things. It's another data point. All I'm suggesting is that if in order to respond to Ann's request, there needs to be a... You need to give an applicant some sort of guidelines on how to define these things a little better. And for some projects it'll be very localized.

Ann Monroe Thank you for that clarification.

Ann Monroe I'll leave it to the department to come up with a way to do that. I do think we want to have some information about how representatives of the community.

Ann Monroe Thank you.

Peter Robinson I think it's a good point. Obviously, this is information that the applicants are going to have to source and provide to the department. We will be cognizant of that and asked the department to do the same as we go forward.

Peter Robinson Thank you.

Peter Robinson Other questions from the committee?

Peter Robinson Is there anyone from the public that wishes to speak on this application?

Peter Robinson I understand applicants are questions only.

Peter Robinson All in favor?

All Aye.

Peter Robinson Thank you.

Peter Robinson Any opposed?

Peter Robinson Noting Dr. Kalkut’s recusal.

Peter Robinson That motion carries.

Peter Robinson Thank you.

Peter Robinson I'm going to call application 2 2 1 0 5 4 C, Canton, Potsdam Hospital in St Lawrence County. Noting of conflict and recusal by Mr. Thomas, who is here and left the room. This is to certify 15 additional medical surgical beds, construct a four-story addition to include 60 single bedded rooms and expansion of the emergency department and shelf space and renovate the existing emergency department. The department is recommending approval with conditions and contingencies.

Peter Robinson A motion by Dr. Gutierrez, a second by Dr. Torres.

Peter Robinson Ms. Glock.

Shelly Glock Thank you.

Shelly Glock Canton Paxton Hospital is the 94 bed not for profit hospital located in Potsdam, St. Lawrence County. They are seeking approval to construct a four-story addition which will include 60 single bedded rooms, some shelf space and an expansion and renovation of the existing emergency department. Canton Potsdam is one of five hospitals in the Saint Lawrence County and is the only hospital in the county that's designated as a level three trauma center. The greater availability of single occupancy rooms and the new bed tower will enable Canton Potsdam to provide a more patient centered experience. Canton Potsdam Hospital has been unable to fully utilize the 63 current med surge beds due to accommodation of patients requiring single occupancy rooms either due to isolation needs, gender or separation of a pediatric adult population. The new four-story building is expected to alleviate this issue and expand capacity to meet demand. The new certified bed capacity, including all bed types, will be 109 beds, of which 78 will be MED. Rochester Regional Health is the sole corporate member and active parent of the Saint Lawrence Health System, who is the active parent cooperator of Canton Potsdam Hospital, Governor Hospital and also Massena Hospital. Approval of this project will expand the ED, as I mentioned, and modernize the rooms containing the MED surge beds to meet the current and future needs of the residents of Saint Lawrence County. The total project costs are going to be funded through up operations, equity and bond financing. Based upon a review of corporate compliance, public need and financial feasibility, the department is recommending approval with contingencies and conditions.

Peter Robinson Thank you.

Peter Robinson Questions from the committee?

Peter Robinson Anyone from the public wishing to speak?

Peter Robinson Questions only from the applicant.

Peter Robinson Thank you.

Peter Robinson Glad to see there are some additional beds as part of this application following on my earlier comment. Need to be encouraged.

Peter Robinson With that I will call the question.

Peter Robinson All in favor?

All Aye.

Peter Robinson Any opposed?

Peter Robinson Any abstentions?

Peter Robinson Noting Mr. Thomas's recusal.

Peter Robinson The motion carries.

Peter Robinson Thank you.

Peter Robinson Ambulatory Surgery Application 2 1 2 2 7 1 C, Ambulatory Surgery Center of Niagara in Niagara County. This is to convert that center from a single specialty in ophthalmology ambulatory surgery center to a multi-specialty ambulatory surgery center and to perform the requisite renovations. Department is recommending approval with conditions and a contingency.

Peter Robinson Motion by Dr. Gutierrez. Second by Dr. Torres.

Peter Robinson Ms. Glock.

Shelly Glock Niagara Ambulatory Surgery Center, LLC, which is doing business as the Ambulatory Surgery Center of Niagara is an existing Article 28 located in Niagara Falls. The application seeks approval to convert from a single specialty ambulatory surgery center to a multi-specialty and to perform the requisite renovations. The center is currently certified for ophthalmology. Approval of this application will add orthopedic and pain management to become a multi-specialty ambulatory surgery center. The applicant reports that the center can handle additional surgery procedures in addition to the eye surgeries they're currently performing. A board-certified physician specializing in interventional pain management has expressed interest in performing approximately 480 pain management cases per year. A board-certified physician specializing in orthopedics has expressed interest in performing about 86 spine pain management cases. There will be no changes proposed to the membership structure or the executed transfer agreement with Mount Saint Mary's of Niagara Falls. The project cost of approximately 158 million will be met with equity from existing operations. The center is current with its sparks reporting. Based upon a review of regulatory compliance, public need and financial feasibility, the department is recommending approval with conditions and a contingency.

Peter Robinson Sorry, momentary distraction there.

Peter Robinson Pardon me.

Peter Robinson Questions from the committee?

Sabina Lim I have a question.

Peter Robinson Thank you.

Sabina Lim In the section on the operating budget where it references revenues from Oasis. And then in the next page, it references that this Oasis revenue would be from pain management cases. I'm just not familiar with Oasis reimbursing or paying for services that are not under the 32 license. I just wanted to just double check and make sure if that's something different that they're doing or that just needs to be looked at.

Jeffrey Kraut Got to ask the applicant.

Peter Robinson Yeah.

Nancey Agard I'll defer to the applicant on that question.

Peter Robinson Can we have the applicant come forward, please?

Peter Robinson I don't have anybody listed here.

Jeffrey Kraut Is somebody representing the applicant that's in the room?

Peter Robinson Yeah, we don't have anybody listed as signed up.

Jeffrey Kraut That's unfortunate.

Shelly Glock We can get that clarified for the full council meeting.

Jeffrey Kraut Could I make a suggestion that, you know, we do encourage all applicants to when they are before us, to have some representation here. It's quite disappointing not to see this applicant. Having said that, depending on the nature of the questions, let's at least get the questions out. Let's have the discussion with the applicant and get a written response prior to the full council meeting on June 2nd, so we don't keep, you know, kind of delaying and building back the agenda. In addition to Dr. Lim's question, I have a question is that they're saying they're going to perform 566 surgical procedures and pain injections. I'd like to know the breakdown of how many are surgical procedures and how many are pain injections. And then the question I would ask is, where are those pain injections being administered now? What's the benefit of administering them in an ambulatory surgery center, aside from the obvious financial benefits? So, from a clinical perspective, why is it more important to do a pain injection there? Those are questions I would ask them.

Peter Robinson I think those are important enough questions. What I would actually like to suggest is that we bring this application up just prior to the full council meeting. A special meeting of the committee just before for this one application, just so that we can have the applicant present and we can have a conversation with them.

Jeffrey Kraut I'm not against that. I just want to point out we are going to have a packed agenda on the second. I've asked in accordance with the request of the council, I believe. Is Bret joining us? We're going to have Bret come and I want to make sure I have ample time. I'm sorry, Bret Friedman, who's the state Medicaid Director, to come and talk about the waiver and some of the you know, they're kind of at the end of a public comment period and just to understand the perspective. I'm not against it. Let's just make sure that for our purposes, we convene it early. Don't convene it at 10:00. Just convene it at 9:30, please. If we can get a quorum.

Jeffrey Kraut Let's take the logistics offline and we'll make a decision.

Peter Robinson This without the applicant responding to those questions.

Jeffrey Kraut If you get a written response and you send it out and everybody is satisfied, we can let the Chair make that decision.

Peter Robinson Dr. Berliner.

Dr. Berliner I'm not sure I heard this. What's the relationship?

Shelly Glock The hospital is not part of the operating.

Peter Robinson It's a freestanding ambulatory surgery center.

Dr. Berliner Have we contacted the hospital to get their take on this expansion?

Shelly Glock We did. We contacted Niagara Falls Memorial Medical Center, Mount Saint Mary's Hospital, and also the Ross Memorial and Niagara Falls Memorial Medical did respond just refuting some of the assertions that the applicant made about understaffing and availability of OR's and wait times in the area, but they did not oppose the application.

Dr. Berliner Thank you.

Dr. Berliner I can't see. Who else?

Peter Robinson Oh, Dr. Torres.

Peter Robinson Thank you.

Dr. Torres I just want to point out that we should be mindful of exceptions that are made for one entity and the potential of other applicants in a similar situation, and thus accommodating accordingly. Just want to put that out there.

Peter Robinson Thank you very much.

Peter Robinson Ms. Monroe.

Ann Monroe I just want to point to this application, because it does exactly what Jeff and I were talking about. It talks about a 20% Medicaid economy, which frankly I think is low. Their visits have been less than 5% Medicaid. It would seem to me that they are not yet meeting the community's overall needs. But I like that compares that it would look for that compares.

Peter Robinson I think you're right. I think the problem with the historical data is that that is primarily ophthalmology, ophthalmology, ambulatory surgery is principally Medicare. It usually... I mean, there are modest percentages of commercial and Medicaid. But just by virtue of the discipline and the types of procedures, you're not going to get a high Medicaid percentage, even if the population would suggest otherwise.

Ann Monroe It's 13% in the community and yet less than 4% or I don't know what the numbers are, but I don't want to belabor this. I just made the point, and we will look at that going forward.

Shelly Glock I can respond.

Shelly Glock Thank you for the question.

Shelly Glock We did discuss that with the applicant with the proposed utilization budget. They are expecting that a large portion of those cases, because of the ophthalmology, will be performed on people in the county who are enrolled in Medicare managed care. You'll see that there is a substantial increase in their budget through year three of the Medicare managed care percentage, recognizing that the Medicaid is below the county average.

Peter Robinson Okay.

Peter Robinson I think we are going to defer this application for now, tentatively a special meeting of the committee recognizing Dr. Torres's comment here. I think we also and I

know you do stress to applicants that they do need to be present when their applications are being considered at the committee so that we have the opportunity to directly question them.

Peter Robinson We are moving on.

Peter Robinson Do you need a motion to defer?

Shelly Glock I just wanted to understand. Yeah, we do need to have a formal action on the project, but I wanted to just make sure I understood what you are proposing to do as it relates.

Peter Robinson We're deferring the application to another session, which may or may not be a special meeting of the committee prior to the full council meeting.

Jeffrey Kraut e to be now. We're not approving it contingent on this.

Shelly Glock I understand that, but what I'm just saying is that you can defer the project without...

Peter Robinson A motion.

Shelly Glock Adding any other context to when it is going to be reconsidered.

Jeffrey Kraut A motion to defer and then leave it up to the department.

Peter Robinson Very good.

Peter Robinson Dr. Gutierrez and Dr. Torres, I think you made the motion and the second. Would you be willing to withdraw your motions?

Peter Robinson Thank you.

Peter Robinson I guess I now need a motion to defer this application.

Peter Robinson Thank you, Dr. Berliner.

Peter Robinson Second, Dr. Gutierrez.

Peter Robinson All those in favor?

All Aye.

Peter Robinson Any opposed?

Peter Robinson The motion carries.

Peter Robinson Thank you.

Peter Robinson Application 2 2 1 0 6 5 C, Elizabeth Seton Children's Center in Westchester County certify a 96-bed residential health care facility for a young adult

demonstration program to be constructed at 315 North Street in White Plains. Here, the department is recommending approval with conditions and contingencies.

Peter Robinson A motion, please.

Peter Robinson Dr. Torres.

Peter Robinson Second by Dr. Kalkut.

Peter Robinson Ms. Glock.

Shelly Glock Elizabeth Seton Pediatric Center is 169 bed voluntary, not for profit Article 28 Residential Health Care Facility in Yonkers. They're requesting approval to construct a new 96 bed building for a young adult demonstration program at 315 North Street in White Plains. This freestanding building will be in close proximity to the Elizabeth Seton current pediatric center. Upon approval, the center will be named the Elizabeth Seton Young Adult Center, and it will serve young adults between the ages of 18 and 35 who are medically fragile. This application is one of two demonstration programs created under the New York State Public Health Law, Section 2808E, which took effect on August 17th, 2021. The new law recognizes the unique challenges of caring for young adults with medical fragility who are aging out of our pediatric nursing homes. Specialized young adult units such as the one proposed by Elizabeth Seton will provide a continuum of care for medically fragile children in transition to young adults, resulting in more positive outcomes. The experience gained in these demonstrations is expected to inform future program and policy formation regarding this special population. The proposed layout of the new center is a five story L-shaped asymmetrical design with centralized space between two wings. The first floor the centralized space will consist of the entryway, a chapel, a large open lobby, a café with seating for 48, as well as the therapy gym with ADL kitchen, adaptive technology room and two multipurpose rooms. The resident floors two through five will have a similar way out. Each floor will have a total of 24 beds composed of 10 double bedrooms and 4 private rooms. The rooms will be spacious enough for ventilator dependent residents and feature ADA accessible bathrooms with a shower with resident dining space on each centralized floor. The second floor will also feature a family lounge for overnight family visits. Third floor will feature a resident spa. The fourth and the fifth floor will feature an additional resident activity room. The size of the proposed 96 bed demonstration program is based upon the applicant's historical experience serving an ageing pediatric nursing home population. Their collaboration with other pediatric providers who face similar challenges in finding appropriate placement for young adults with medical fragility and the applicant's understanding of the longer-range needs of this medically fragile population in the geographic locations served. The total project cost of 118 million will be met through a HUD mortgage and an equity raised by Elizabeth Seton Children's Centre. That includes capital campaign funds, donations from foundations and pledges an individual contribution. The Department has reviewed this project for public need, financial feasibility and regulatory compliance, and we are recommending approval with contingencies and conditions.

Peter Robinson Thank you for that.

Peter Robinson I'll turn to the committee first for any questions.

Peter Robinson Dr. Berliner.

Dr. Berliner What happens if the demonstration doesn't work out?

Shelly Glock If the demonstration doesn't work out, then these beds would be considered RHCF beds. They're subject to RHCF reimbursement.

Dr. Berliner Is there enough bed capacity to absorb those new beds if the demonstration doesn't work out?

Shelly Glock Well, we wouldn't necessarily there wouldn't be discharge from the facility. Those will be residents who will be aged out of the pediatric facility. They'll be receiving the same services that Elizabeth Seton is known for, their quality for their pediatric residents. They'll be cared for in this facility. The demonstration project is really around the aged out in providing a budget-based reimbursement rate for those children who right now there is no care settings. Children who age out of pediatric facilities would need to be placed in geriatric facilities who would not necessarily have the expertise in pediatric. This is a demonstration project to address the fact that children are living longer, they're aging out of the pediatric facilities, and it's a demonstration project around meeting those specialize. These are children who have very medically complex care needs, and they are often difficult to place into a facility without those specialized training and programs.

Jeffrey Kraut I'd be very surprised if not only with this program, but I think, you know, knowing the provider, knowing the unique need that I'd be very surprised if this program is not successful only because running a children's hospital and being involved, there's such a demand for this. The economics of the current system failed to provide adequate reimbursement for this particular cohort that is extraordinarily medically fragile. From a social and developmental perspective, you know, putting them in adult geriatric nursing homes are not our best option. I suspect this. It's a demonstration project that we may see. There's probably more need than actually may be filled here, but time will tell. I wouldn't be surprised if we saw other applicants, you know, geographically around the state to do this.

Dr. Berliner Thank you.

Peter Robinson Any other questions from the committee?

Peter Robinson I'm assuming the applicants are questions only.

Peter Robinson I think this is a terrific application. I'm delighted that it's come before this committee.

Peter Robinson With that, I'm going to call the question.

Peter Robinson All in favor?

All Aye.

Peter Robinson Any opposed?

Peter Robinson And no abstentions.

Peter Robinson That motion carries.

Peter Robinson Thank you.

Peter Robinson Wish the applicant the best of luck. This is just a remarkable project and a meeting a very important community and statewide need.

Peter Robinson Thank you.

Ann Monroe And that there were two proposals or two sites. Has the other was put before us, or what is the plan for the second site? Is the department reviewing their applications? I think it's called Sunshine Rehab.

Shelly Glock The second demonstration project is with Rutland Nursing Home in Brooklyn. That application is under review. It will be coming.

Ann Monroe Thank you.

Peter Robinson Very good.

Peter Robinson Moving on for two applications for establishment and construction. This is for a diagnostic and treatment center.

Peter Robinson Yeah, just want to be sure there's no recusals here.

Peter Robinson This is application 2 1 2 2 5 8 B, Rego Park Counseling LLC doing businesses Rego Park Diagnostic and Treatment Center in Queens County. This is to establish and construct a diagnostic and treatment center at 63-36 99th Street in Rego Park, co-located with mental health and substance use disorder services. Also, I want to note that on page one and five of the exhibit, the proposed ownership percentage should be Emmanuel Callender of 90% and Raul Lower M.D. 10%. The department is recommending approval with conditions and contingencies.

Peter Robinson A motion by Dr. Gutierrez and a second by Dr. Torres.

Peter Robinson Ms. Glock.

Shelly Glock Rego Park Counseling doing business as Rego Park Diagnostic and Treatment Center is an existing New York LLC and the current operator of an Article 32 outpatient Office and Addiction Services and Support Program. Requesting approval to establishing construct in Article 28 Diagnostic and Treatment Center at the same address as the current Oasis program. The proposed DNTC will provide primary care and other medical specialties, including gynecology, podiatry, gastroenterology, pulmonology, pain management, orthopedics and a variety of other services that you can see in the exhibit. The applicant has also applied to the Office of Mental Health for the establishment of an Article 31 outpatient mental health clinic in the same building. With the three co-located clinics, Rego Park Counseling seeks to reduce preventable admissions for patients with co-occurring conditions of substance abuse, mental health issues and medical conditions. Each licensed program will be separate and distinct from the others. In the proposed members of Rego Park Counseling in the percentages, as Mr. Robinson pointed out. Is the owner of Rego Park Counseling. He's also the Medical Director of Westchester County Correctional Facility and basic residential. He is board certified in medical family medicine and he'll serve as the Medical Director. Is the managing member of Rego Park, where he manages the day to day operations. Elmhurst Hospital. He also discloses ownership interest in Rego Park Counseling that you can see in the exhibit. Elmhurst Hospital,

located two miles away, has communicated support with the transfer agreement. The applicant is projecting 4,367 visits in year one, with almost 8,600 in year three with a Medicaid utilization of 65% in charity care at 2%. The project cost will be met with members equity and a bank loan. We are recommending, based upon review of character and competence, public need and financial feasibility. We are recommending approval with conditions and contingencies on the project.

Peter Robinson Thank you.

Peter Robinson Turn to the committee for questions.

Sabina Lim I have a quick question for the applicant.

Peter Robinson Can we have the applicant come forward, please.

Peter Robinson Please introduce yourselves.

Peter Robinson Thank you.

Peter Robinson Please go ahead with your question.

Sabina Lim Thank you.

Sabina Lim It's great to see this project. I just have a quick question about sort of. It's great to have all three types of care located in one spot, but as you know, just physically locating them together doesn't necessarily mean that you can integrate the care. Are you planning to eventually apply for an IOS or are there other ways that you're thinking about how you're going to operationalize integration between the three different services, so from the patient's perspective, it's a little more seamless.

Applicant We've already had discussions about pursuing the IOS model and we need to be in operation first for a period of time before we can seek that. We'll discuss that with OMH and Oasis and the Health Department.

Sabina Lim Terrific.

Sabina Lim Thank you.

Peter Robinson Thanks for that question.

Peter Robinson Any other questions from the committee?

Peter Robinson Thank you very much.

Peter Robinson Is there anyone else from the public that wishes to speak on this application?

Peter Robinson All in favor?

Peter Robinson Any opposed?

Peter Robinson Any abstentions?

Peter Robinson Motion carries.

Peter Robinson Thank you.

Peter Robinson Application 2 0 1 2 2 2 E, True North three DC LLC doing business as Grand Boulevard Dialysis in Suffolk County. Noting a conflict and recusal by Mr. Kraut. This is to establish True North three DC LLC as the new operator of the 20 station Chronic Renal Dialysis Center located at 860 Grand Boulevard in Deer Park that is currently operated as an extension clinic of Bronx Dialysis Center. The department is recommending approval with conditions and contingencies.

Peter Robinson A motion, please.

Peter Robinson Dr. Torres and a second by Dr. Berliner.

Peter Robinson Ms. Glock.

Shelly Glock True North DC three LLC is an existing New York LLC and they're requesting approval to be established as the new operator of Grand Boulevard Dialysis. Grand Boulevard is a 20 station Article 28 renal dialysis center located in Deer Park, Suffolk County. After the change of ownership, will continue to operate the facility under the name Grande Boulevard Dialysis, with no changes to stations or services. There is an organizational chart before and after the transaction in the attachments, the BFA attachments to the exhibit. You'll notice that the current operator is Knickerbocker Dialysis, and that Knickerbocker Dialysis is owned by DaVita. This is a DaVita Inc owned facility. Is comprised of True North DC holding at 80% membership entity and that 80% is comprised of Knickerbocker Dialysis, 51% in North Shore, at 49%. The other 20% of True North DC three LLC membership is comprised of Long Island Hemodialysis LLC at 10% in Comprehensive Dialysis Care LLC at 10%. Again, that exhibit, that organizational chart is contained in the attachment. Long Island Hemodialysis LLC is comprised of one-member, sole member, Dr. Sager, and Comprehensive Dialysis Care is comprised of one member, and that is a Dr. Chang. Northwell Health is the parent and sole member of Northshore LIJ Renal Ventures LLC. DaVita Inc is the parent of Knickerbocker. Knickerbocker is the licensed operator of 61 chronic renal dialysis facilities in New York State, while is the operator of more than 2,600 facilities in the United States. I'm guessing you understand now why we put the organizational chart in the exhibit. As I mentioned, is the sole member of Long Island Hemodialysis. He'll continue to serve as Medical Director. He is board certified in internal medicine with a subspecialty in nephrology. Dr. Chang is the sole member of Comprehensive Dialysis LLC. He is a nephrologist currently employed at Long Island Kidney Associates PC, and is board certified in internal medicine with a sub certification in nephrology. True North three DC LLC will enter into a consulting and Administrative Services Agreement to provide accounting, billing, funds, management and other type consulting and administrative services. The facility's location and the primary service area of Suffolk County will remain unchanged, as will the transfer backup hospital with South Side. There are no project costs associated with the application. True North three DC LLC will purchase the operating interests to be funded by for about 5.3 million to be funded by proposed members contributions and a bank loan. Based upon review of character and competence, public need and financial feasibility, the Department is recommending approval with conditions and contingencies on this project.

Shelly Glock Thank you.

Peter Robinson Questions from the committee?

Peter Robinson Dr. Gutierrez.

Lito Gutierrez Thank you. Thank you very much.

Lito Gutierrez I am concerned about the structure of this. Particularly as it relates to the institution, an institution that I've had concerns about in the past, and I want to repeat the concerns today. My comments now apply to this application 2 0 1 2 2 E on the next application 2 0 1 2 4 4 E . I am reading this and I am making this pamphlet available. You can access it if a colleague is able to pass it on to you if you wish. Let me start by saying that in November 2019, Eliason, Hibbs, MacDougall and McDevitt and Roberts published an article in the Quarterly Journal of Economics titled, quote How Acquisitions Affect Firm Behavior and Performance: Evidence from the Dialysis Industry. Unquote. The quoted Journal of Economics Volume 135, Issue 1 on February 2020. Pages 221 to 67 contain the article in full. The reference you can directly click on to hypertext will be available to you. The Quarterly Journal of Economics is a peer reviewed academic journal published by the Oxford University Press for the Harvard University Department of Economics. This is not a medical journal. This is not a journal that I would have as a physician access independently. I got a copy of it. I don't remember exactly how he said it got to me. In its abstract it reads the following, and this is verbatim. Many industries have become increasingly concentrated through mergers and acquisitions, which in healthcare may have important consequences for spending on outcomes. Using a rich panel of Medicare claims data for nearly 1 million dialysis patients. We advance the literature on the effects of mergers and acquisitions by studying the precise ways providers change their behavior following an acquisition. We base our empirical analysis on more than 1,200 acquisitions of independent dialysis facilities by large chains over a 12-year period and find that chains transfer several prominent strategies to the facilities they acquired. Most notably acquired facilities converts to the behavior of their new parent companies by increasing patients' doses of highly reimbursed drugs. Replacing high skilled nurses with less skilled technicians. Waiting listing fewer patients for kidney transplants. We then showed that patients fare worse as a result of this changes outcomes such as hospitalizations and mortality deteriorate with our long panel allowing us to identify this effect from within facility or within patient variation around the acquisitions. Because overall, Medicare spending increases at acquired facilities mostly as a result of higher drug reimbursements. This declining quality corresponds to a decline in value for payers. We conclude the article by considering the channels through which acquisitions produce such large changes in providing behavior and outcomes finding that increased market power cannot explain the decline in quality. Rather, the adoption of the acquiring firms' strategies and practices drives our main results with greater economies of scale for drug purchasing responsible for more than half of the changes or the change in profits following an acquisition. That is the end of the abstract. The following considerations which are my concerns. The authors reviewed data from a rich panel of Medicare claims for nearly a million dialysis patients. It was clear that the acquired facilities changed their behavior to match the big corporate rules. And that business of reimbursing a change in the patient doses for medications that were highly reimbursed is a source of concern to me as well. The replacing of high skilled nurses for less skilled technicians and wait listing fewer patients for kidney transplant. We know that a kidney transplant is a cure for renal failure. The reader has been notorious in failing to do that compared with other institutions. The paper further show that patients fare worse as a result of changes on outcomes such as hospitalizations and mortality deteriorated. At the time prior to the publication of the paper, the share of independently

owned and operated facilities, dialysis facilities have fallen from 86% to 21%, with DaVita and Fresenius owning over 60% of facilities and owning over 90% of the industry revenues. US Renal Care was marching of the same set and with similar behaviors. The data at that time cover approximately 430,000 dialysis patients amounting to about 33 billion each year, or 6% of total Medicare expenditures. The authors concluded that acquiring facilities alter their treatments in ways that increase reimbursements and decrease cost. For instance, facilities capture higher Medicare payments for Medicare by increasing the amount of drugs they administer to patients for which Medicare paid providers a fixed per unit rate during the study period. The most noteworthy of this is epigenome, or EPO, a drug used to treat anemia, which represented the single largest prescription drug expenditure for Medicare in 2010, at that time, totaling 2 billion, according to the US Government Accountability Office in 2012. Perhaps reflecting the profits at stake, patients EPO doses increase 129% at independent facilities acquired. Similarly, acquired facilities increased their use of the iron deficiency drug, compared to a perfect substitute that offers lower reimbursement. On the cost side, large chains replace high skilled nurses with lower skilled technicians and the facilities they acquire. Facilities also increase the patient load to each employee by 11.7%, an increase in the number of patients treated at each dialysis station by 4.5%, stretching resources and potentially reducing the quality of care received by the patients. Patients that acquire facilities are 4.2% more likely to be hospitalized in a given month, given the survival rate of new patients falls by 1.3 to 2.9%, depending on the time horizon. In addition, new ESR patients who start treatment on an acquired facility are 8.5% less likely to receive a kidney transplant or be added to the transplant waitlist during their first year in dialysis. Since publication of the article, I have brought this concerns up during previous meetings. Applications for approval of acquisitions of dialysis center has slowed only as a result of the pandemic. All applications that have been presented to the council have survived committee scrutiny and have been approved by the full council. To my knowledge. I'm emphatic about this. To my knowledge, there have been no attempt by the industry in general in particular to deny the validity of the findings, challenging the methodology or in any other way show that they have altered their behavior with the patient's well-being in mind. I'm a physician. I'm a board-certified internist. I have a lifelong dedication to primary care. I, like most physicians, have adhered to first, do no harm. I believe that the way that this is dialysis conducted by the big corporate units is not with the patient first and foremost. I wanted to emphasize this today. I understand that this is not just a purchase or transfer. Was involved with it before, but I thought necessary to emphasize that point. I encourage discussion of this if necessary and the article is available. I pass it on to Colleen earlier and is available to all of you.

Lito Gutierrez Thank you very much.

Peter Robinson Thank you, Dr. Gutierrez.

Peter Robinson Just two comments in response. One, just for the standpoint of procedure. Your comments apply at the moment to the application that's before us, even though you did reference the other one, and we'll come to that at the appropriate time. So, just that point. The second issue and maybe this is something to... Unfortunately, Mr. Kraut is out of the room right now, but I think this, too, is a broader topic that ought to go to the Planning Committee, so that there can be a broader discussion about policy and strategy at a statewide level rather than addressing this transaction only with individual applications. Because I do think that this has broader implications. I don't not necessarily sure that all of the concerns that you raised can be addressed through the way that we respond to that one specific application. I certainly respect the real concerns that you

raised and the fact that I think we ought to be paying close attention and better understanding the issues that you're bringing up. I do appreciate very much those comments.

Peter Robinson Thank you.

Peter Robinson I'm going to see if there are other questions now from the committee.

Hugh Thomas Hugh Thomas, member of the committee.

Hugh Thomas This is more of a technical question, not a medical question, because I'm not a doctor. I appreciate Lito's comments earlier. Very narrowly. Shelly, I think this is a question for you. This is and I know there are two applications. I'll just start with this one. This is an existing operator that is being essentially a joint venture with Northwell, correct? Northwell is not presently an operator, so it is inserting itself and investing in this operation and becoming a partner in this transaction. Is that correct?

Shelly Glock That's correct.

Hugh Thomas From that perspective, the change would be the introduction of a large nonprofit integrated delivery system in the State of New York into this center.

Shelly Glock That's correct.

Hugh Thomas Thank you.

Hugh Thomas I read it. I looked at the diagram. I just want to make sure I had it right.

Hugh Thomas Thank you.

Peter Robinson Dr. Berliner.

Dr. Berliner Shelly, what would...

Shelly Glock I'm sorry, Dr. Berliner. I didn't hear the question.

Dr. Berliner What would Northwell's participation percent be? Would they be a majority owner or a minority owner?

Shelly Glock In this application True North Holdings is going to be operated by owned by 51% Davida and 49% Northshore Renal Ventures. It's a 49/51 split.

Dr. Berliner Thank you.

Shelly Glock That's just 80% of the membership and then you've got the two other LLC's whose sole members are physicians making up the 20%. It's 51 and 49 of 80% membership.

Dr. Berliner A couple of years ago, Shelly, you might remember, though, Lito, you would probably remember there was a similar application with Northwell willing to invest or allow to buy in into a dialysis center. It was a similar situation where.

Peter Robinson I'm assuming that somebody has a dog at home. Could you please mute?

Dr. Berliner We ended up turning down the application. I'm wondering how similar is what is this application to that one from a few years ago if anyone remembers that.

Shelly Glock I don't know specifically what prior application you're referring to, Dr. Berliner, but it sounds like it's probably a similar type structure where Northwell or I should say True North was coming in and you know that DaVita was divesting themselves of ownership of the dialysis center by partnering with True North Holding.

Peter Robinson I admit that I don't recall clearly. I do think that you are correct that there was an application where essentially, I think it was the percentage ownership was actually going to be diluted. But because of the broader concerns that were raised, that application I believe was not approved. This goes back to Mr. Thomas's point that actually a greater percentage of ownership moving to a not-for-profit health system in New York State is actually, and now I'm speaking for me a positive in this climate, rather than having that not happen and the ownership structure remained where it was.

Peter Robinson Dr. Kalkut, is that you?

Dr. Kalkut Yes.

Dr. Kalkut Thanks, Peter.

Dr. Kalkut I'd add I remember similarly that there have been applications like this and I think all entitled True North with a similar percentage for the members of True North. And then adding physicians, I think from the community as minority owners in this. I don't recall. I think some of these have been approved by the EPRC. I do remember a long discussion about whether getting nonprofits involved was, in fact, a net positive for delivery of this kind of care.

Peter Robinson Thank you.

Peter Robinson So, actually, to get back to you, Ms. Glock, the percentage ownership, if you combine the Northwell piece and the doctor piece actually together is a majority ownership, and therefore DaVita is actually less than a 51% owner of the entire operation in the makeup of this particular application. Is that correct?

Shelly Glock That's correct. Because 49/51 of the 80.

Peter Robinson Of the 80.

Peter Robinson But then there's two more tens.

Peter Robinson Which is actually Mr. Thomas's point as well.

Peter Robinson Yes, Dr. Gutierrez.

Lito Gutierrez In this particular situation, I'm particularly concerned or interested to know whether the people that I asked him to come in, the 10% MD and the 10%. Victor Chang, MD. These are my colleagues, the board-certified internist. I would like to ask them if they

are aware of this article and what response they have about it. If they are present, they would like to ask the question.

Peter Robinson Well, can we maybe have the applicant come to the table?

Peter Robinson Thank you.

Peter Robinson You have a team.

Frank Cicero Yes. Yes. We thought that was appropriate.

Frank Cicero I'm Frank Cicero. I'm a consultant to the applicant.

Frank Cicero I'm going to pass it down the line and let each person introduce themselves.

Peter Robinson Thank you.

Harvey Rodriguez Good morning. My name is Harvey Rodriguez, and I'm the Chief Executive Officer.

Peter Robinson Thank you.

Dr. Jeff Gillain Good morning. I'm Dr. Jeff Gillian. I'm a board-certified nephrologist, board certified in internal medicine and a former transplant nephrologist. I now serve as the Chief Medical Officer.

Betsy Good morning. I'm Betsy. I am the Deputy General Counsel.

Peter Robinson Thank you.

Applicant I'll send it along. After each person introduces themselves, I'll make a brief statement. And then, Dr. Gutierrez, I'll turn it over to Dr. Fishbein from Northwell to speak to some of your points.

Applicant Thanks.

Steve Good morning. Steve. I'm a virologist. The Chief of Academic Nephrology at Northwell Health and a Professor of Medicine at the Hofstra Northwell School of Medicine and the Chief Medical Officer for the True North Joint Venture, which is the partnership between DaVita Northwell and certain physicians.

Steve Thank you.

Larry Thank you.

Larry Good morning. I'm Larry. I'm the General Counsel for the hearing.

Peter Robinson Hey, Gary, can you go on mute?

Adam Good morning. I'm Adam. Senior Vice President of Strategic Business Initiatives for Northwell Health.

Peter Robinson Thank you.

Applicant So, just briefly to explain what this transaction is, there's been a lot of discussion about that. These are two sites that DaVita constructed. They did not acquire them. They constructed them anew. I'll start with this application. This application commenced operations in 2019. This application does represent the dilution of ownership. Currently owns 100%. It will reduce its ownership to 40.8%. It represents the introduction of local ownership, control and quality. And just to give a little history, there was a True North One and True North Two that this council approved that brought Northwell into the ownership of similar situations. There was a True North Four and Five that did not go forward after receiving positive votes from this committee. And there was one other application that was not a True North application, but was a DaVita owned entity where physician ownership was brought in that was approved by the council. It did not move forward. So, that's the history coming to this time. I would add just one other thing on quality for DaVita in New York State, focusing on New York State. In the state as of April 2022, DaVita facilities have a 3.7 CMS star rating on average, with only 5% of the facilities having two stars or fewer. All other facilities in New York State have a 3.3 CMS star average with 21% of facilities having 2% or lower. I thought that was important to get on the record.

Applicant I'll turn it over.

Applicant Thank you.

Applicant The first thing that I would like to say, and I'll be brief, is that this committee did turn down two years ago a partnership between us and DaVita within the True North Framework in Queens. However, it's really important to note that we've gone forward in other situations. We have 15 operating dialysis units today that have been operating for years now under True North. Four years, five years as a partnership of DaVita and Northwell and with physicians in one case. They have been a tremendous success from the standpoint of quality. I don't know, you know, turning down the dialysis facilities in Queens a couple of years ago, what it would have meant. This partnership has been tremendously successful from the standpoint of quality, patient safety, patient satisfaction, and it's documented in public reporting. This has been a very highly successful partnership. It sounded with respect to Dr. Gutierrez, who, you know, I think raises an interesting point from the article, but it sounded as if the DaVita is coming in and taking over dialysis facilities. But no, you know, as I think the clarification was already made. I'll be a little bit redundant here. These are dialysis units. This dialysis unit and the first application is fully owned by DaVita right now. We're simply seeking permission to bring in Northwell and to bring in physician owners so that like the other 15 units that we currently operate, that we can provide the same level of quality, patient satisfaction, patient safety, high transplant rates. This has been a wonderful service to the community and for people with this incredibly difficult disease. This is the permission that we seek.

Peter Robinson Thank you.

Peter Robinson Dr. Gutierrez, you have a comment or question?

Lito Gutierrez Thank you very much for your comments.

Lito Gutierrez As a physician, were you aware of this article and had you read it?

Applicant I am aware of most of what is in there. But no, Dr. Gutierrez, not this specific article.

Applicant Thank you.

Lito Gutierrez Are you aware of any effort to answer the article to address the concerns brought up in the article?

Applicant I'm not. But look, since it's a court and I can do more than just dance, it's not a court. I can do more than just say yes or no. I would like to say that whatever the questions that were raised there and they sound very reasonable. I know you have a great concern in terms of patient care and have been an advocate for such for many years. But again, Dr. Gutierrez, you know, we have really put a lot over the last five years into this partnership. We operate 15 dialysis units together and have provided a very high level of quality. I will say definitively every issue that you raised from the article, none of them have existed throughout this partnership. In terms of DaVita nationally, they can comment in terms of more national issues, but this partnership has been highly, highly successful, and there really have not been any problems at all.

Peter Robinson Thank you for that response.

Peter Robinson Mr. Thomas.

Hugh Thomas Hello, everyone. Thank you for your time this morning. Just a follow up on my comments earlier, which is and I think you answered it, Doctor. Mr. Cicero, I think the data that you may want to share at some point is the data associated with your 15 joint venture centers, not the entire state. Not that it isn't relevant, it is for the State of New York. This application in particular represents a significant change in the ownership of a site that it owns and operates. I don't know the answer, but basically what I just heard from your colleague is that the 15 are operated well with high quality some might suggest because of the partnership. I don't that's more of a statement than a question. You see where I'm going, Frank.

Peter Robinson Just have sort of a follow on with Mr. Thomas's comment there. I think that, for example, you know, the percentage of fewer patients that actually end up moving to transplant, it may be different than DaVita nationally or even DaVita in New York State. You may have a more positive track record there as well. I think it would be to your benefit to bring that up if that's in fact, the case.

Applicant Thank you for the opportunity, Mr. Robinson.

Applicant So, yeah, indeed, there is public reporting for dialysis care, and this is under very, very high scrutiny. Of the dialysis facilities that we operate, they're not all ratable yet by the government, but of those that are, seven of them have five stars. Only 10% of American dialysis unit reach that level of quality. That's phenomenal. Our transplant rates right now are higher than New York State average is not for DaVita for all New York State operating programs. If people are interested in specific aspects of quality, I mean, I can certainly speak to any of them, but these are very, very highly performing facilities that are above general New York State averages.

Peter Robinson Those are very helpful comments and I think that's what Mr. Thomas was trying to find out.

Peter Robinson I'm sorry, did you want to say anything there?

Applicant I would like to comment. Dr. Gutierrez, first of all, I share in your passion for patient care. As a Chief Executive Officer of DaVita, I have read the article that you mentioned. I can produce articles, of course, that say the opposite of that. We could all produce articles with an opinion. But let me take each if there's three premises, and I think it's worth addressing them if the committee would find useful. The first one is that there's an increase in drug expense. We wanted to defect that and be as clear as possible. We went to the administration, and we worked together as a community, and we now have a bundle reimbursement. The cost of the drugs are no longer relevant. That was an important step forward on that. It's just number one. Number two, the doctors make all the prescription drugs decisions, not the company. That is a local decision by nephrologists in the community. That is no longer something to discuss. Two, you talk about staffing. Staffing, of course, is a challenge in all health care services at this juncture. But we are, as you know, checked by the conditions for coverage and surveyed at all points. We take enormous pride in our track record. Three, you talk about transplant. The real issue with transplant, unfortunately, is organ supply. You could say, boy, we want more people on the wait list. At some point, if you don't get called upon, it's not that useful to be in a waitlist. We take enormous pride in the work that we're doing with the American Kidney Fund and trying to get more organs. Number two, we just acquired a company that helps most patients simplify the process of getting on the wait list. I'm confident that we will lead on that waitlist. Point number three is that we are educating all of our patients on transplant from the beginning. So, literally you get modality education, transplant education, and you go through your journey. We look forward to showing you the stats as that plays out. And then sort of lastly, you talk about hospitalization. We track that information incredibly closely. We have the lowest hospitalization we've had in the history. We've been tracking this for over two decades. We have the lowest hospitalization we've ever had. As it relates to mortality, of course, that information right now is very complicated with COVID and what that's doing to that. I hope that that's responsive to the article because we take care incredibly seriously.

Peter Robinson Thank you very much.

Peter Robinson Mr. La Rue.

Mr. La Rue Good morning. Scott, member the council. I just have a quick question for the department. Why are there so many names listed in the star ratings? Is it because they haven't been in existence long enough to have a rating?

Shelly Glock According to the CMS website, there is not enough data available to in order for them to report a quality measure. It could be that they are just recently up and running facilities. I don't know the specifics of each of those, but generally that's what's listed on the CMS website under NA, that there's just not enough data to make that determination.

Applicant And additionally, I'll just add that during COVID, CMS put a halt on doing that data collection and data analysis. We anticipate later this year or early next year, beginning to see CMS data come out again.

Peter Robinson Thank you.

Peter Robinson Any other questions from the committee?

Peter Robinson Dr. Gutierrez.

Lito Gutierrez Yes.

Lito Gutierrez In the group?

Applicant They are not today.

Lito Gutierrez I'm sorry, I forgot your name.

Javier Rodriguez Javier Rodriguez.

Lito Gutierrez Has the reader published a rebuttal of the article?

Javier Rodriguez We publish our outcomes and you know, as you know from research, you can pick and choose your data. We don't refute everything that's published. We just publish our quality outcomes and our results, which are very clear and transparent and are different than what that article says.

Lito Gutierrez I understand the person to your right is a physician.

Javier Rodriguez Yes.

Lito Gutierrez Could I ask that question to that colleague, please?

Lito Gutierrez I'm sorry. I didn't have a chance to read your name.

Jeff Gillian I'm Jeff. Gillian.

Lito Gutierrez Dr. Gillian, were you aware of the article?

Jeff Gillian I was.

Lito Gutierrez What's your response to it?

Jeff Gillian Similar to what Javier Rodriguez mentioned is this article and the conclusions in it do not reflect what the data shows at all. This article uses data that is up to two decades old. It draws conclusions on a lot of laboratory values. As a practicing physician, I can tell you during that time, our focus on some of those laboratory values, ours, meaning the physician's focus, not dialysis industry or anything else, changed because scientific evidence changed. It is true that over the past two decades, as that data was being utilized, practice patterns did change. But fortunately, what I experienced both when I was in practice and caring for patients and what I experience now as the Chief Medical Officer is that physicians make decisions on prescribing dialysis, how to prescribe dialysis, and only physicians prescribe dialysis.

Lito Gutierrez Who controls?

Jeff Gillian All health care, in my opinion, is local. Our medical directors, in the case of this joint venture, which has its own chief medical officer, which is Dr. Fishbein, they are

the ones, and the prescribing physicians are the physicians who choose how to prescribe the dialysis modality and the medications that go with that dialysis.

Peter Robinson Thank you.

Peter Robinson I certainly allow you to make any other comments you'd like to make. I think that we've exhausted our questions and appreciate all of you being here. It's quite a significant representation, and we do appreciate that. You don't need to go very far. As a matter of fact, I think I'll let you just stay right there, because we do have another application for you to discuss. I do also want to make sure that I've created an opportunity for anybody from the public that wishes to speak on this application.

Peter Robinson I'm going to call the question.

Peter Robinson All in favor?

All Aye.

Peter Robinson I think we're going to need a roll call.

Colleen Dr. Kalkut?

Colleen Actually, I think he might have stepped off.

Dr. Kalkut I'm here.

Dr. Kalkut Yes.

Colleen Dr. Berliner?

Dr. Berliner No.

Colleen Dr. Gutierrez?

Colleen You're on mute, Dr. Gutierrez.

Lito Gutierrez No.

Colleen Mr. Holt?

Mr. Holt Yes.

Colleen Mr. La Rue?

Mr. La Rue Yes.

Colleen Mr. Lawrence?

Mr. Lawrence Yes.

Colleen Dr. Lim?

Dr. Lim Yes.

Colleen Ms. Monroe?

Ann Monroe Yeah.

Colleen Mr. Thomas?

Hugh Thomas Yes.

Colleen Dr. Torres?

Dr. Torres Yes.

Colleen And the Chair?

Peter Robinson Yes.

Colleen Motion carries.

Peter Robinson The motion carries.

Peter Robinson We thank you very much.

Peter Robinson As I said, please don't go anywhere. We are going to call the next application. Mr. Kraut remains recused for this application as well. 2 1 1 2 4 4 E, True North six DC LLC doing business as Peconic Bay Dialysis and Suffolk County. To establish true North six DC LLC doing business as Peconic Bay Dialysis as the new operator of Peconic Bay Dialysis, a 13-station chronic renal dialysis facility at 700 Old County Road, Suite four in Riverhead and on Long Island, currently operated by Knickerbocker Dialysis Inc. The Department is recommending approval with conditions and contingencies.

Peter Robinson A motion, please.

Peter Robinson Dr. Torres.

Peter Robinson A second, Dr. Berliner.

Peter Robinson Ms. Glock.

Shelly Glock True North six DC LLC is an existing New York LLC and this application is requesting approval for True North to be established as the new operator of Peconic Bay Dialysis Center. Peconic Bay is the 13th station Article 28 Chronic Renal Dialysis Center, located in Suffolk County in Riverhead. After the change of ownership so currently similar to the last application. DaVita is a 100% owner of this facility. After the change of ownership, True North six DC LLC will continue to operate under the name Peconic Bay Dialysis. You can see from the exhibit that the membership of True North in the exhibit shows that the proposed operator True North DC Holding LLC will have a 90% membership and Fox Run Holding Company LLC will have a 10%. Fox Run Holding LLC has one sole member, a Dr. Kumar and True North DC Holdings, similar to the last application, is comprised of Knickerbocker Dialysis Inc and 51% and Northshore Renal

Ventures at of 49%. Again, it's a dilution of the DaVita ownership. I ran the math on this one and I believe it put to be that about 46% North Shore at about 44 and then Fox Run at approximately 10. Again, Northwell Health is the parent so member of North Shore Renal Ventures. Is the parent of Knickerbocker and Dr. Kumar is a nephrologist at Long Island Community Hospital. Our Brookhaven Health Care Rehab Facility and Belle Haven Nursing and Rehab. He is board certified in internal medicine and board eligible nephrology. He will serve as the facility's Medical Director. Backup Hospital is Peconic Bay Medical Center and True North six DC LLC will enter into a consulting and administrative services Agreement with DaVita Inc. The submitted budgets are in the exhibit. Based on a review of character and competence, public need and financial feasibility, the Department is recommending approval with conditions and contingencies.

Peter Robinson Thank you.

Peter Robinson Questions from the committee?

Peter Robinson I'm assuming the applicant has questions only.

Peter Robinson Thank you.

Peter Robinson Anybody from the public wishing to speak on this application?

Peter Robinson I'm going to call the question.

Peter Robinson I'm going to do a roll call again.

Colleen Dr. Kalkut?

Dr. Kalkut Yes.

Colleen Dr. Berliner?

Dr. Berliner No.

Colleen Dr. Gutierrez?

Lito Gutierrez No.

Colleen Mr. Holt?

Mr. Holt Yes.

Colleen Mr. La Rue?

Mr. La Rue Yes.

Colleen Mr. Lawrence?

Mr. Lawrence Yes.

Colleen Dr. Lim?

Dr. Lim Yes.

Colleen Ms. Monroe?

Colleen She's not there.

Colleen Mr. Thomas?

Hugh Thomas Yes.

Colleen Dr. Torres?

Dr. Torres Yes.

Colleen And the Chair?

Peter Robinson Yes.

Colleen Motion carries.

Colleen Thank you.

Peter Robinson That motion carries.

Peter Robinson Thank you all for coming here.

Peter Robinson I really appreciated the conversation and the presentation. It was very informative. I think having this kind of an approach going forward is going to be very important, I think, for the committee on the council as a whole.

Peter Robinson Thank you very much.

Peter Robinson Can get Mr. Kraut back in the room.

Peter Robinson Calling application 2 0 2 1 0 6 E, Montgomery Operating Company LLC doing business as Montgomery Nursing and Rehabilitation Center in Orange County. This is to transfer a total of 99% ownership interest from four withdrawing members and one existing member to six new members. The department is recommending approval with a contingency. A motion by Dr. Gutierrez. A second by Dr. Torres.

Peter Robinson Ms. Glock.

Shelly Glock Montgomery Operating Company, LLC, the operator of a 100-bed proprietary Article 28 RACF facility located in Montgomery, Orange County, is requesting approval to transfer 91% ownership from four withdrawing members and 8% from one remaining member to six new members. There will be no change in beds or services provided as a result of this project and the current and proposed membership ownership of Montgomery Operating Co LLC is shown in the exhibit with the four new members. Yosef is a New York State licensed nursing home administrator. He's employed as the administrator of Water View Hills Rehab and Health Care. He discloses no health facility interest. Ari is a corporate purchaser for Epic Senior LLC, a management company for skilled nursing facilities. He discloses no health facility interest. Ethel is a New York State

licensed pharmacist. She discloses no health care facility interest. Is the office manager for Royal Home Improvements, which is a general contractor business. Discloses no health care facility interest. Finally, also discloses no health care interest except for a 5% interest in Hollis Manor Nursing Home. I should have phrased that differently. He discloses health care facility interest in Hollis Manor Nursing Home. Herbert is the managing partner of Epic Health Care Management, a management company for residential health care facilities. He lists concurrent employment as the managing partner at Sky View Rehab in Health Care Center and Director of Water's Edge Health Care in New Jersey. He discloses health care facility interests in seven New York State nursing homes, as well as some out of state facility that you can see depicted in the exhibit. The proposed owners have been evaluated on the distribution of CMS star ratings for their portfolios, as per our recently adopted 10 NYCRR Part 600.2. For all the proposed owners, the distributions of star ratings for their facilities meet the standards described in that regulation. If you take a look at the exhibit, you will see that Herbert currently has ownership interest in eleven nursing homes. Two of those he has owned under 48 months. You'll remember that the regulation in the calculation of the 40% only includes nursing homes that a proposed applicant has owned for 48 months or longer. In the portfolio, he has nine nursing homes and the percent with below average rating is 33%. Who owns one nursing home that he has owned longer than 48 months? That nursing home is above the star rating threshold. Those are the proposed operators for this nursing home. The subject facility has an overall star rating of three. The long-term care is recommending approval on the project, but does note in the recommendation that they do not have a regular presence in the facility. Based upon a review of character and competence and financial feasibility, the department is recommending approval with a contingency.

Peter Robinson Thank you.

Peter Robinson Questions from the committee?

Peter Robinson Hearing none.

Peter Robinson Anything from the applicant?

Peter Robinson Only questions.

Peter Robinson Anybody from the public wishing to speak on this application?

Peter Robinson Hearing none, I'm calling the question.

Peter Robinson All in favor?

All Aye.

Peter Robinson Any opposed?

Peter Robinson Motion carries.

Peter Robinson Thank you.

Peter Robinson Application 2 0 2 2 6 9 E, Ross OPCO LLC doing business as Ross Center for Nursing and Rehabilitation in Suffolk County. This establishes Ross OPCO LLC as the new operator of Ross Center for Nursing and Rehabilitation, which is an existing

120 bed skilled nursing facility located at 839 Suffolk Avenue in Brentwood. The department is recommending approval with a condition and contingencies.

Peter Robinson Motion, please.

Peter Robinson Thank you, Dr. Torres.

Peter Robinson Second, Dr. Berliner.

Peter Robinson Ms. Glock.

Shelly Glock Ross OPCO LLC doing business as Ross Center for Nursing and Rehab is requesting approval to be established as the new operator of Ross Center for Nursing and Rehab, which is a 120-bed proprietary Article 28 RHCF located in Suffolk County. Ross Center for Nursing and Rehab is the current operator of the facility, and Ross OPCO LLC is the real property owner. The proposed operator of Ross OPCO LLC sole member is SSNY Holdco LLC. The members of SSNY are Shalom Stein at 50%, Nathan Stein and Paret Stein, each at 25% for a total of 100. Stein is a New York New Jersey State licensed nursing home administrator. He lists his employment that you can see in the exhibit. He's President of Peace Capital LLC, Complete Care Management LLC, which he indicates is a multi-state owner and operator of skilled nursing, assisted living and independent living facilities. He discloses interest in a large number of out-of-state facilities which are included in the exhibit. Lists employment as the CFO of the Subject Facility Ross Center for Nursing and Rehab. He indicates he has no health facility interests. Stein is a licensed nursing home administrator in the State of New York and New Jersey. He lists his employment as the administrator of the subject facility, Ross Center for Health and Rehab. Prior to that, he indicates work as administrator at previous facilities, but discloses no health facility interest. The proposed operators have been evaluated for distribution of the star ratings in relationship to 600.2 and for the proposed owners, the distribution of star ratings meets the standard. As you can see in the exhibit, Stein owns a total of 53 nursing homes. 42 of them he has owned for less than 48 months. A large portion of those were acquired in 2021. 11 nursing homes, he has ownership interest longer than 48 months and just 27% of those are below an average rating, so below the threshold is set in regulation which allows us to bring the application forward. Upon approval of this application, Ross Center will lease the premises to a non-arm’s length lease, as the membership of the realty company Ross Prop Co is the same as that of the operating company. Based upon a review of character and competence and financial feasibility, the Department is recommending approval with a condition and contingencies.

Peter Robinson Thank you very much.

Peter Robinson Questions, please.

Peter Robinson Ms. Monroe.

Ann Monroe Just for clarification, is this the first New York nursing home that these owners will be operating?

Shelly Glock That's correct, Ann. This will be the first New York State facility that the three proposed members of the operating entity will have an ownership interest. However, as I did note in the project description, two of the members, one is currently the administrator of the facility and the second member is currently, I believe, the CFO of the facility. I did

not mention previously, but I'd like to that the long-term care ombudsman program has recommended approval. They do have a regular and consistent presence in the facility. I also took a look at the survey findings for Ross, the subject facility. It appears that the surveillance findings have improved in the facility since 2018. It looks like their health deficiency tags have actually dropped in half and they were all low-level deficiencies at the last recertification survey, which was in July of 2021. Based upon the review of those survey findings and the review of the Ombudsman Program recommendation, we are recommending approval.

Peter Robinson Thank you.

Ann Monroe Remind me of Ross's star ratings. I missed it in the report. I'm sorry.

Shelly Glock They're a three-star overall facility with five for quality measures and two for staffing and health inspections.

Ann Monroe Thank you.

Peter Robinson Okay.

Peter Robinson Other questions?

Peter Robinson Applicant questions only.

Peter Robinson Anybody from the public wishing to speak?

Peter Robinson Hearing none, I'll call the question.

Peter Robinson All in favor?

All Aye.

Peter Robinson Any opposed?

Peter Robinson Any abstentions?

Peter Robinson The motion carries.

Peter Robinson Thank you.

Peter Robinson Noting an interest by Mr. La Rue in application 2 1 1 1 3 9 E, Village Acquisition One LLC doing businesses Lower West Side Rehabilitation and Nursing Center. This is in New York County. Established Village Acquisition One LLC is the new operator of Village Care Rehabilitation and Nursing Center, a 105-bed residential health care facility located at 214 West. I call it Houston. They call it Houston Street. New York. Approval with a condition and contingencies is recommended.

Peter Robinson A Motion by Dr. Gutierrez. A Second by Dr. Torres.

Peter Robinson Ms. Glock.

Shelly Glock Village Acquisition One LLC doing business as a Lower West Side Rehab and Nursing Center is requesting approval to be established as the new operator of Village Care Rehab and Nursing Center, which is an existing not for profit 105 bed facility located in New York. Upon approval of this application, the site will be named Lower West Side Rehab and Nursing Center. There will not be any changes in beds, services or utilization in the area as a result of this change in ownership. The proposed operating membership you can see in the exhibit is made up of six individuals. Reports concurrent employment as the CFO at DeWitt Rehab and Nursing and a managing member. Is an organization that delivers rehab and nursing services. He's previously worked as a CFO and controller at a large number of long-term care facilities since 1997. You'll see in the exhibit that he does disclose ownership interest in a large number of health care facilities. Alex is a New York State licensed physical therapist. He reports concurrent employment as the CEO at rehab and nursing, Director of Rehab at Thermodynamics and a managing member. Since May of 2021, Alex has been under an employment agreement with Village Center for Care to act as the Director of operations of the Nursing Home. He discloses ownership interests in the health care facility shown in the exhibit. Joseph is a New York State nursing home administrator in good standing. He also discloses ownership in several RACF's that you can see in your exhibit. Michael Schreiber is a managing member and regional administrator. He's a licensed New York State Nursing Home administrator. He discloses ownership interest in several facilities as well. And finally, Jimmy reports employment as the senior vice president in business development. He discloses ownership interests in the Upper East Side Rehab and Nursing Center. Looking at the portfolio, the proposed owners have been evaluated on the distribution of star ratings and meet the standards described in the state regulations, allowing us to move the application forward for consideration. The proposed owner's portfolio includes ownership in 12 New York State facilities. 11 facilities have a CMS overall quality rating of average or higher while only one facility had a CMS quality rating of below average. The Long-Term Care Ombudsman program has a presence in 3 of those 12 facilities and is recommending approval of the project. Based upon a review of character and competence, financial feasibility, the Department is recommending approval with a condition and contingencies.

Peter Robinson Thank you.

Peter Robinson Questions, please.

Peter Robinson Applicant questions only.

Peter Robinson Anybody from the public on this application?

Peter Robinson Seeing none, I'll call the question.

Peter Robinson All in favor?

All Aye.

Peter Robinson Any opposed?

Peter Robinson Thank you.

Peter Robinson We are now up 1 9 2 0 2 6 E, Eastside OPCO LLC doing businesses as Eastside Nursing and Rehabilitation. This is in Wyoming County, up in our neck of the woods, Ann. Established Eastside OPCO ILC, is the new operator of the 80-bed residential

health care facility located at 62 Prospect Street in Warsaw, currently operated as Eastside Nursing Home. The department is recommending approval with a condition and contingencies.

Peter Robinson A Motion by Dr. Gutierrez and a second by Dr. Torres.

Peter Robinson Ms. Glock.

Shelly Glock Eastside OPCO LLC doing business at Eastside Nursing and Rehab is requesting approval to be established as the new operator of Eastside Nursing Home, which is an 80-bed proprietary Article 28 RACF located in Wyoming County. Currently, Eastside Nursing Home Inc sole member is John Bartholomew Senior, and the real property is owned by Eastside JM OPCO LLC, which purchased the property in December of 2018. Upon approval of the application, the facility will be named Eastside Nursing and Rehab. Eastside is currently a CMS five star rated facility. The proposed operator of East Side OPCO. Members are CMEJM OPCO Holdings, LLC. You can see in the exhibit that there are four members of that LLC, Jennifer, Eli, Josh and Michael. Josh Brown will be the managing member. There will be no changes to beds or services. I do want to note that concurrently under review by the department is another CON in which the proposed members of this application are seeking approval to acquire the operating interests of Cress Manor Living and Rehab also an 80-bed facility located in Monroe County. Is a licensed New York nursing home administrator. He reports concurrent employment as the COO at Cress Manor and Eastside Nursing and Rehab, which is the subject facility. He has prior employment as a licensed nursing home administrator and he discloses ownership interest in one facility, Park Avenue Health Care Health Center, which is a Massachusetts nursing home which he acquired in September of 2021. Jennifer is employed as a real estate consultant. She discloses a 15% interest in Cress Manor Rehab in the real property. She's also on the CON that I mentioned for Cress Manor and the operating entity. Eli Gerber reports self-employment, real owner of a realty company in New Jersey. He has no health facility ownership disclosed. Finally, Michael Lebowitz. I apologize if I'm mispronouncing your name. Discloses no health facility ownership as well. I spoke that Josh Brown had an ownership interest in Park Avenue Health Center in Massachusetts. You'll note in the exhibit that this facility did have two harm level enforcement related to resident abuse very early on after acquiring the facility. He became part of the ownership entity in September of 2021. These instances occurred in September of 2021 and November of 2021. The department did review very carefully the survey findings related to those citations. We do concur with the applicant statement that steps taken to address those issues, including replacing the administrator and the director of nursing and retraining all staff in in abuse education and reporting was appropriate and timely corrective action. The current occupancy of the facility is 98.8% as of 5/11/22. Acquire the operations for $100,000 funded by members entity equity. There are no project costs. The budget appears reasonable. Long term care ombudsman recommendation, which you will see in the attachment, is recommending approval with a contingency that the applicant commit to addressing some of the physical environment situations in the building, including a leaky roof and some cooling issues. Based upon a review of character and competence and financial feasibility, the Department is recommending approval with a contingent and contingencies.

Peter Robinson Thank you.

Peter Robinson Questions, please.

Jeffrey Kraut The ombudsman, whether or not we put it in as a contingency, which is a little unique for us. It's a leaky roof and a what?

Shelly Glock There are some cooling issues with the building.

Jeffrey Kraut Could we get the applicant to come up and just maybe that's the best way to deal with it.

Jeffrey Kraut Ann, did you have a...?

Peter Robinson One thing at a time.

Jeffrey Kraut Okay, I'll just...

Peter Robinson Go ahead.

Jeffrey Kraut Could you just identify yourselves.

Andrew Black Good afternoon. Andrew Blatt, consultant to the applicant.

Josh Brown Hi. Josh Brown, applicant.

Jeffrey Kraut You heard the report from the long-term care ombudsman, a leaky roof and cooling issues. Do you have a plan to address those concerns?

Andrew Blatt Yes, if you want, I can answer for them.

Andrew Blatt Thank you very much.

Andrew Blatt They've actually been aware of this issue. There's five existing mechanical units on the roof. Four of them are actually slated to be replacement. A proposal was signed, and the equipment has been ordered. Unfortunately, it's going to take a little bit longer than it used to pre-COVID days. I hate to say it. They believe that the leaks are actually coming from the rooftop curbs where the existing mechanical units are sitting on. When those units are removed and replaced, the curbs will be refreshed and knock-on wood that the leaking will stop.

Peter Robinson Ms. Monroe.

Ann Monroe Yes. This is a really interesting kind of thing for us to follow. We have a five-star nursing home here in Warsaw and it's coming under new management. Whether or not it's reflective of your general performance or not. You had one- and two-star nursing homes in other states. Is there a way that we can track, in particular, this kind of situation to assure that that five star credit, especially in rural New York, which is highly valued and highly prized, remains a five star facility. Usually, we see the other. We see a one- or two-star facility where somebody comes in and we're going to improve it and do all these things. This is a little bit different. It is five stars. We want to be able to keep it there. My concern is that the operations that these new owners have run have not been up to that standard. What could we as a council do to track this or to see how this develops over time so that it could be a learning process for us?

Peter Robinson Do you want to respond first?

Shelly Glock Thank you for the question.

Shelly Glock Just to clarify, the proposed operator is not the current operating entity in the subject facility, so they disclose employment in the facility.

Shelly Glock Excuse me.

Shelly Glock That I highlighted. The facility that we were talking about, the one-star facility is located in Massachusetts, and that's the facility that was acquired recently as of September of 2021. It hasn't even been a year, yet that Mr. Brown has disclosed interest in that facility. That's the facility that I took a look at what occurred in that facility. What actions did Mr. Brown take, even in a short period of time of two months in that facility. We feel that, you know, the short period of employment, our ownership history there based on what occurred to make it a one star, he took appropriate action. In terms of your questions about ongoing monitoring, that's why we have a surveillance program for, and we also have the long-term care ombudsmen, who I believe have a presence in this facility. Here's a case where with the new legislation with the long-term care ombudsman recommendation, where the two pieces really complemented each other, I think, and came together. That is something that we expect all applicants to be compliance with all regulations at all times. The surveillance program is how we monitor that.

Ann Monroe Well, perhaps. I really appreciate that, Shelly. I'm sure you guys internally are on top of that. If it doesn't burden our agenda too often, maybe once a year you could make a presentation as to what's happened with decisions we have made in the shorter term, because it feels like we don't have any way of learning from our processes, because the surveillance is all internal to the department. I defer that to Jeff and to you to see if there's an annual report, we could have at one of our meetings or whatever that tells us how the decision we made have played out.

Peter Robinson In other words, what's the result of our approvals in terms of how these facilities are performing on an ongoing basis.

Jeffrey Kraut Well, you know, this gets back to the long-term care policy and, you know, kind of annual reporting that we should do. I mean, I think it's easy enough for us to look at all the applications we approved, the date we approved it and the ratings they got and then looked forward. I mean, it just takes a little bit of staff work. Right now, I know the department is having is a challenge just to keep up with the work we're trying to do. I think that's easy enough to do. If the department can't do it, I'm sure we'll get somebody to do that. It's a good resource to have as a companion when we have these discussions. I think it's a good idea. It can't be difficult to pull together.

Peter Robinson Mr. La Rue and then Dr. Berliner.

Mr. La Rue Yes.

Mr. La Rue Good afternoon. Scott La Rue, member of the council. I've been relatively quiet here today on these nursing home applications, because I'm really grateful for the department and the new approach that we have to reviewing nursing homes. When these applications come before now, I think we have a quantitative metrics, and we know that they've been well vetted when they get to this point. This application, and I'm asking this, Ms. Glock. I believe, you know, there is a threshold of how many you have to own before

certain requirements kick in or how long you've owned the nursing home. This individual is only involved in two. It doesn't fall in the bucket of meeting the requirements of having, what is it, five or more? Could you just update us on that?

Shelly Glock Yes, I'd be happy to.

Shelly Glock Thanks for the question, Scott.

Shelly Glock The new regulations set a threshold that for any proposed applicant, if their portfolio contained five or more nursing homes that they had ownership interest in for 48 months or longer, that those facilities, if they owned five of 48 months or longer, if they had more than 40% facilities that were not three stars or above, it would be an automatic disapproval. We would not be able to move the application forward. For those facilities with less than five facilities in the portfolio, which would be the situation here that those would be. There's no threshold for automatic disapproval, obviously, because they don't own five. Those applications would be brought forward for consideration of all of the other factors that we've always considered being the surveillance history, experience of the applicant and our confidence in their ability to run a quality organization. That's why I, I took a look at what, you know, what occurred in that one facility, which is really the only facility we have surveillance history on under their ownership. And also, you know, we really worked with the ombudsman program who has the presence knowing that the proposed operator are in there operating the facility not as a legally recognized operator, but I believe as COO. To take a look at what's going on in the facility in terms of a track record of being responsive. So, that's when the ombudsman program came back and said that they would recommend approval, but they'd like to see those two situations we spoke about addressed. It's a case-by-case basis with no automatic disapproval threshold if under five facilities.

Peter Robinson Thank you.

Mr. La Rue And if I could just follow up by, I would just add the 48 month is there because of the timing that it takes to get surveys, to get the CMS results and to give an operator time to improve the facility. It just can't happen overnight. It's the same way with less than five facilities. A good operator can you know, unfortunately can have a bad survey that's out of character for them. It allows that subjectivity here to look at the whole picture, as Ms. Glock was just suggesting with this one. Again, I want to reiterate my support and thanks to the department. It's been a long time coming as we've worked our way through these. I think we're in a great place now for reviewing these nursing home applications.

Peter Robinson Thank you.

Peter Robinson Dr. Berliner.

Dr. Berliner Shelly, I think this application and maybe the last one you've mentioned that the long term had a presence in the facility. What does that mean?

Shelly Glock The ombudsman program has some of their staff are paid state staff and some staff are volunteers. They're volunteers who go into the facilities. They ensure that quality of life issues. They are advocates for the residents in those facilities. Sometimes there's a facility, Dr. Berliner, that they don't have a staff person or a volunteer available to regularly visit that facility. The ombudsman program is simply noting in facilities that they aren't into regularly. They want to make sure that that's part of your decision making as part of the recommendation.

Dr. Berliner Thank you.

Peter Robinson Very good.

Peter Robinson Assuming now it's just still just questions, right?

Peter Robinson Anybody from the public wishing to speak on this application?

Peter Robinson All in favor?

All Aye.

Peter Robinson Any opposed?

Peter Robinson Any abstentions?

Peter Robinson The motion carries.

Peter Robinson Thank you.

Peter Robinson Moving to certificates.

Peter Robinson The first one is certificate of amendment of the Certificate of Incorporation. This is for Saint Barnabas Nursing Home Inc request consent for filing a name change and change purposes. Department is recommending approval.

Peter Robinson Motion by Dr. Gutierrez. Second by Dr. Torres.

Peter Robinson Any questions from the committee?

Peter Robinson All in favor?

All Aye.

Peter Robinson Any opposed?

Peter Robinson Motion carries.

Peter Robinson Mr. La Rue, you are recused from this next one.

Peter Robinson Thank you.

Peter Robinson This is for residents. This request consent for filing to dissolve. Here, the department is recommending approval.

Peter Robinson May I have a motion?

Peter Robinson Dr. Gutierrez.

Peter Robinson Second, Dr. Torres.

Peter Robinson Any questions from the committee?

Peter Robinson All in favor?

All Aye.

Peter Robinson Any opposed?

Peter Robinson The motion carries.

Peter Robinson That concludes the agenda for this committee meeting for today. I want to thank the department staff for yeoman's work to get ready for this. We were well-prepared. Much appreciated. Also thank the members of the committee for their time and attention and effort and commitment. The full council will be meeting on June 2nd in New York City, and there will be an Albany site that's open. It would be helpful for all of you to let the staff know where you intend to be. We are looking forward to seeing everyone.

Jeffrey Kraut It's also at 90 Church.

Peter Robinson Yes, that's where the main meeting is going to be. Albany will be open, but the main meeting will be in 90 Church. There's still a Zoom option. Sorry, I needed to mention that.

Peter Robinson Okay, we are adjourned.